Authorization for Release of Information

Alaska Psychiatric Institute
Telebehavioral Healthcare Services
(Provider Please Fax Completed Form to 269-7129)

Section 1

I, _____ DOB: _____ SS#: _____
hereby authorize:

_____ ☐ To Release to _____
(Name of Person/Agency) (Name of Person/Agency)

_____ ☐ To Exchange with _____
(Address) (Address)

_____ ☐ Exchange Verbal Information _____
(City, State, Zip Code) (City, State, Zip Code)

Section 2

The following specific information:

____ Mental Health Evaluations/Assessments ____Social Histories ____ Hospital Discharge Summaries
____ Psychiatric Evaluations ____ Substance Abuse Records ____ Academic Records/IEP
____ Medical History and Physical/Labs ____ Psychological Evaluation
____ Other: _____

for care received from: _____ to _____

Section 3

The purpose of the release of this information is:

☐ Sharing with other health care providers as needed ☐ My personal records ☐ Legal
☐ Other – Please specify _____

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised.

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may be asked about the services I received from API in order to provide program improvement feedback. Any requests for program feedback are completely voluntary and I can decline to answer any or all questions.

This authorization expires on the following date or event: _____ or 90 days from the completion of services.

_____ / _____ _____ / _____
(Signature of Witness) (Date) (Signature of Patient (Date)

_____ / _____ _____
(Signature of Guardian) (Date) (Relationship to Patient)

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient has revoked on _____(date)